

# ATHLETE MEDICAL FORM

# SPECIAL OLYMPICS CONNECTICUT

**LOCAL PROGRAM:** PLEASE CHECK  NEW  RENEWAL

Name (First – Last): \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender  Male  Female Phone Home: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**PLEASE LIST PARENT OR GUARDIAN INFORMATION BELOW**

Name \_\_\_\_\_

Address (if different than athlete's) \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail \_\_\_\_\_

**EMERGENCY CONTACT IF DIFFERENT THAN PARENT OR GUARDIAN**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Type: \_\_\_\_\_

**HEALTH HISTORY TO BE COMPLETED BY PARENT/CAREGIVER**

**AN UP TO DATE HEALTH HISTORY AND A PHYSICAL EXAMINATION PERFORMED BY A LICENSED EXAMINER IS REQUIRED UPON ENTRY INTO THE PROGRAM. A PHYSICAL EXAMINATION IS REQUIRED EVERY 3 YEARS FOR ATHLETES WITH "YES" RESPONSES TO ITEMS 1 -5. A PHYSICAL EXAMINATION IS REQUIRED FOR ALL ATHLETES WITH A "NEW" RESPONSE TO ITEMS 7-11. ATHLETES MUST SUBMIT THIS FORM EVERY 3 YEARS WHETHER OR NOT AN EXAMINATION IS NECESSARY.**

1. HEART PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	9. SURGERY OR ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	17. EMOTIONAL/BEHAVIOR PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO
2. CHEST PAINS <input type="checkbox"/> YES <input type="checkbox"/> NO	10. HEAT STROKE/COLD ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	18. BONE OR JOINT DISORDER <input type="checkbox"/> YES <input type="checkbox"/> NO
3. SEIZURES/EPILEPSY <input type="checkbox"/> YES <input type="checkbox"/> NO	11. OTHER PROBLEM (S) THAT WOULD INTERFERE WITH SPORTS PARTICIPATION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	19. SICKLE CELL/TRAIT DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO
4. DIABETES <input type="checkbox"/> YES <input type="checkbox"/> NO	LIST: _____	20. HEARING AID <input type="checkbox"/> YES <input type="checkbox"/> NO
5. DOWN SYNDROME <input type="checkbox"/> YES <input type="checkbox"/> NO	12. IMPAIRED MOBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	21. CONTACTS/EYEGASSES <input type="checkbox"/> YES <input type="checkbox"/> NO
5a. Atlanto-Axial Instability present <input type="checkbox"/> YES <input type="checkbox"/> NO	13. DEAF <input type="checkbox"/> YES <input type="checkbox"/> NO	22. DENTURES/FALSE TEETH <input type="checkbox"/> YES <input type="checkbox"/> NO
5b. If yes, X-ray date _____	14. SPECIAL DIET <input type="checkbox"/> YES <input type="checkbox"/> NO	23. DATE OF LAST TETANUS SHOT ____/____/____
6. BLIND <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	15. ASTHMA <input type="checkbox"/> YES <input type="checkbox"/> NO	24. INSECT STING ALLERGY <input type="checkbox"/> YES <input type="checkbox"/> NO
7. ABSENCE OF KIDNEY/TESTICLE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW	16. BLEEDING PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	25. MEDICINE ALLERGY (LIST BELOW) <input type="checkbox"/> YES <input type="checkbox"/> NO
8. HEAD INJURY/CONCUSSION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		26. FOOD ALLERGY (LIST BELOW) <input type="checkbox"/> YES <input type="checkbox"/> NO

Check all that apply  Non Verbal  Walker  Crutches  Wheelchair  Hepatitis

**LIST MEDICINE ALLERGIES:** \_\_\_\_\_ **LIST FOOD ALLERGIES:** \_\_\_\_\_

MEDICATIONS: PLEASE PRINT MEDICATION NAME, AMOUNT AND NUMBER OF TIMES PER DAY MEDICATION NEEDS TO BE TAKEN BELOW: (USE ADDITIONAL PAPER IF NEEDED)

\_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**LICENSED EXAMINER AND PARENT/CAREGIVER SIGN AND DATE BELOW**

**EXAMINERS NOTE:** If an athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).

RESTRICTIONS: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

EXAMINERS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

EXAMINERS NAME: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

APPLICANT OR PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED AND DATED TO BE CONSIDERED VALID.**